Early On® Oakland
2111 Pontiac Lake Road
Waterford, MI 48328
248.209.2084
248.209.2522 Fax

Early On® Oakland Request For Protected Health Information

Child's Name:	Birthdate:
Parent(s)/Guardian's Name:	

Medical Provider(s) Authorized to Share Information with Early On®

The purpose of this request is to collect information necessary to determine your child's eligibility for Early On®, and to plan and provide services as determined through the multi-disciplinary team process.

The medical provider(s) listed below have permission to share the specific information listed about my child.

Medical Provider:	Specific information to be shared with Early On®
Medical Provider:	Specific information to be shared with Early On®

Your signature below indicates you understand the following:

- I have read and understand this request form (or it has been read to me in a language I understand.)
- I understand that my authorization to allow the sharing of information about my child is voluntary and expires upon exit of Early On® or my child's third birthday.
- I may revoke or cancel consent at any time, without penalty, by notifying Early On® in writing. Information that has already been shared based on this authorization cannot be taken back.
- Information received under this authorization becomes part of my child's educational record, is protected by Family Educational Rights and Privacy Act (FERPA), and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).
- Information regarding behavioral and mental health services or communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here _____ or if I list this type of information above.
- I may refuse to sign this authorization.
  - Refusal to sign may affect the ability of Early On® to obtain information necessary to demonstrate that my child meets Early On® eligibility criteria.
  - If my child is found eligible for Early On®, refusal to sign this authorization will not affect my ability to obtain Early On® services. However, the information obtained can help provide services that are individualized for my child.

Choose one of the following options:

☐ I authorize the above listed medical provider or designee to engage in verbal, written and/or electronic communication in order to share specified record and information.

OR

☐ I do not wish to have any information shared at this time.

Parent(s)/Guardian Signature:	Date: